# DISCUSSION*

DAN E. BEAUCHAMP, PH.D.
Deputy Commissioner for Planning, Policy and Resource Development
New York State Department of Health
Albany, New York

## How Policy Shapes Politics: The Case of Universal Care

Something of a consensus seems in the winds regarding how national governments limit health care expenditure. In recent reports, the General Accounting Office[1] and the Congressional Budget Office[2], have focused on two or three key elements. These include making insurance more uniform, payment reform for physicians and hospitals, and finally universal coverage.

To find the beginnings of consensus after 25 years of medical inflation should be welcome news for nearly everyone. However, I believe we still view the reform from too technocratic a perspective, devoid of the larger political context that assures its success in the rest of the democracies. Our view is confined to the economics of universal systems. However, a stable health care system is more a political than an economic achievement. Moreover, universal health care, as a policy, changes not just health care but also the politics of health care.

For example, we are all reasonably familiar with the argument that payment reform will contribute to controlling costs. Concentrating payment in a few or one set of hands will increase the likelihood that health care can be bought, and not just paid for.[3] However, is there any larger political meaning to this reform, beyond strengthening the hand of those who negotiate for the public?

Also, what is the larger political meaning, if any, of standardizing insurance products? Why is it necessary to create a uniform, universal benefit for all citizens? Beyond reducing administrative costs, what role does this reform play in achieving stable growth in costs?

Finally, and viewed from the perspective of a new politics of health care, how does universal coverage itself contribute to the battle against medical inflation? To listen to the debate over universal coverage, it might be thought that the only purpose of universal coverage is to eliminate nonpayment, and

*Presented as part of a symposium, *Dr. David Axelrod and the Health of the Public: Looking Ahead*, cosponsored by the New York State Department of Health, the New York Academy of Medicine, and the Josiah Macy, Jr. Foundation October 23, 1991.

thereby stop cost-shifting among providers. Surely most recognize that universal coverage affords some more fundamental role in a national strategy for controlling costs, but just what is it?

Answers to all of these questions might very well add up to a theory of the politics of universal health care, a theory of how universal health care is implemented in society and carried out.

Such a theory would primarily lay out the politics of universal systems. Presently, the politics of universal health care—the pattern of political relationships standing behind universal systems and systems of social welfare more broadly—are seldom brought into the discussion at all.

Such a theory would identify the major features of universal health care systems and the role they play in producing systems stability. Such a theory would help pinpoint more clearly the role of government in such systems—including state governments—and the role of public opinion and the electorate. Such a theory would help us debate more intelligently where we should administratively locate the organizations who manage universal health care. Should it be a new department in the executive branch of government? Should it be something separate, like the Federal Reserve system, as Peter Diamond suggests? [4]

Indeed, discussion of the politics of universal health care is perhaps the biggest gap in our current debate over how to reform the health care system.

I think I know why we ignore this subject, beyond our usual aversion to politics. Typically, nearly everyone thinks that policies are shaped by politics. Politics, in turn, are framed by institutions and values. Our health care system, then, is the result of our (decentralized, diffuse) federal political system and our individualistic, incremental values. The basic political question is whether these institutions and values can manage and sustain universal health care, even if we manage to pass it sometime in the near future. Many think not.

The problem with the equation—politics shape policies—is that it is a half-truth. The reverse is also true: policies shape politics[5], often powerfully so. More than this, the politics of universal health care, and the social insurance system of which it was a part, were designed to forge a new politics, to change politics. Universal health insurance, like pension reform and workers' compensation, were conceived originally by political leaders as a strategy to enlarge the sphere of a politics of equality and security.[6]

For the United States, the question may not be so much whether our politics can accommodate and manage universal health care. Rather, the question is whether the universal health care system we adopt will transform

our politics sufficiently to assure stability and affordable growth. This political perspective is the focus of my brief observations.

## How Policy Shapes Politics: Three Preliminary Hypotheses

The General Accounting Office, in Inspector General Bowsher's April 1991 testimony to Congress suggested three critical elements of any stable universal health care system: standardizing the insurance product, including coverage rules, payment reform, and universal coverage. The GAO's list is a good place to start. I will comment on each step on their list, trying to show how they can be linked to a larger political theory for the implementation of universal health care. While I take up each step separately, it should be born in mind that universal health insurance means the operation of these three steps in concert, as part of an overall system of universal entitlement.

### 1. Standardizing insurance benefits

To begin with, the theory of universal health care, and of social insurance more generally, was to create a new politics, a politics of equality. How this was to occur can be stated quite simply. By creating systems of social security for pensions, unemployment, work place injury, and for sickness for the entire population, the advocates for these schemes sought to enlarge the realm of security in democratic capitalism. By arranging for this security to be available to everyone, on a contributory or tax-financed basis, the reformer sought to make these benefits widely popular and politically stable. Because everyone benefitted more or less on an equal footing in this form of communal welfare, everyone would seek to defend it from its enemies.

Another source of stability, beyond joining the poor and the middle classes into common systems of provision, was to isolate and defend these benefits from the ordinary market and its logic. Not to do so would so be to invite instability and transformation from pressures to make provision private and commodity-like in its operation. In the sphere of communal welfare, the reigning virtues are stability, standardization, and security; in the realm of the market, the reigning virtues are competition, rivalry, and difference.

Universal health care, among all forms of social insurance, was especially important because of the fact that social provision could easily be arranged in a system that everyone would use and share.

Given this background, what are we to make of the goal of standardizing insurance products? Obviously, we can eliminate much confusion and administrative waste by standardizing and making more uniform the health

insurance product, and by using a common electronic billing and claims system. These are integral to the UNY*Care proposal.[7]

Also, by standardizing coverage rules we advance on the goal of restraining unwarranted expansion of physician and hospital billings.

However, standardizing insurance has a much larger political goal. That goal is to transform insurance from a commodity that spreads through a process of differentiation and segmenting the market into a commodity that is standard and more or less jointly shared. Put another way, the goal is to strengthen the sense among the citizenry that health insurance is a common product and a common interest.

This reform, coupled with universality discussed below, adds up to creating a sense that the public faces rising health care costs as a group, and not just as individual consumers.

Of course, the degree to which this occurs will likely depend on precisely how similar each person's coverage is to everyone else's. In the English and the Canadian systems that similarity is exact. In Germany, there are differences, albeit slight, in health insurance benefits.[8] However, the purpose of the reform is to create a sense that everyone participates in the same system, that the interest in health insurance is largely a common one and that everyone is in roughly the same boat.

Standardizing insurance, moreover, also takes as its goal the creation of a clearly-demarcated, well-insulated health care sector, one well defended from too much competition. Such a sector not only re-defines the role of insurance companies but also the role of health care providers in general.

## 2. Payment reform

My second hypothesis is that concentrating and controlling the flow of resources to doctors and hospitals—creating single payer systems—is absolutely essential to a stable health care system.

In most universal health care systems, the flow of resources in the health sector is highly concentrated or coordinated, if not absolutely centralized.[9] For most systems, this concentration is created by government-financed insurance schemes, such as those found in Canada, the Nordic countries, and the national health service of England. In these countries, the government has a virtual monopoly over resources flowing to the medical profession and to hospitals and other health care institutions. Budgets for hospitals and fee schedules for physicians of various stripes are the rule. This concentration of resources into a few hands produces the "bilateral" negotiations that Evans argues is key to cost-restraint in Canada.[10]

Concentrating resources in a single or a small number of hands would have an immediate and substantial impact on our state of affairs. Such a restructuring of payment, and of the fundamental nature of the insurance market, would powerfully shape a visible and direct link between the public and public officials around the interest of managing cost growth. Taxpayer solidarity should be the clear goal. Taxpayer solidarity and premium-payer solidarity would likely rise; benefits solidarity would also rise. Rising costs affect all boats more or less uniformly. (In UNY*Care, we go further, recommending a single card to strengthen this sense of taxpayer solidarity.) The public and public opinion plays a critical role in managing universal health care systems. This feature is starkly absent in our present and pluralistic system for paying providers.

Also, and in a national scheme, because the level of medical provision for the poor and the middle class are more or less the same, and occur within the common framework, the chronic instability that comes from the demands to fund the Medicaid budget could be sharply reduced.

For the United States, the key question is whether a rate-setting, all payer framework will be a sufficient substitute to single payer systems, given the goal of cost stability. Such a framework seems to slow the rate of growth in states like New York and Maryland, at least for a while. Such a scheme is not particularly flexible in directing resources away from expensive settings, like acute care, and into primary care.

The critical question is whether we must somehow create a fixed ceiling for growth for the entire system each year, and develop effective means for achieving this goal. Does "effective means" entail creating some mechanism for controlling the aggregate flows of revenues to hospitals and doctors? In my view, the answer is yes. "Effective means" implies something along the lines of a single payer authority as envisioned in UNY*Care and other proposals before the state. This is a subject on which there remains much to be discussed, debated and decided.

More than this, the process by which the budget for such a system is reviewed, debated, and decided in Congress or at the state level requires the utmost thought and deliberation. Clearly, means must be found to hold legislative and executive branch leaders accountable for too-rapid expansion of the system, as well as for too sharply constraining health care expenditure.

Because resources come from a common, or at least coordinated source, in time we could also expect the support for a more intelligent health planning and budgeting to grow, and for opposition to these measures to lose ground.

### 3. Universal entitlement

Standardizing insurance, coupled with payment reform, are critical to reshaping the politics of health care. However, it is the third step, universal entitlement, that is crucial to a new politics.

My third hypothesis is that universal entitlement creates a politics of equality. The politics of equality is the precondition for a politics of efficiency.

The existence of these separate social markets of common provision are typically justified in Europe in terms of either rights or social solidarity. There equality as universal entitlement is the fundamental precondition for efficiency. In my view, this will be the underpinnings of any successful American universal health care system.

I am aware that, today, we tend to see health policy in terms of the trade-off between efficiency and equality. In my view, this way of thinking suffers from what has been called "the tyranny of false polarities."[11] Universal entitlement to a universal benefit is the linchpin for a successful drive against an inefficient, inflation-ridden health care system.

For example, presently, the health care system is radically decentralized and loosely connected. Cost control as an interest is very weak, diffuse, and shared across three levels of government and myriad private interests. The job of gaining concerted action to stem medical inflation is well-nigh hopeless in such a context. The politics of cost control fosters uncoordinated, ad hoc, and widely-divergent strategies.

It is often argued that the parliamentary system of government is key to the successful management of large-scale systems like universal health care. Parliamentary systems do make the task of forging a politics for equality far easier, but the existence of Social Security and the politics it has engendered are powerful counter-arguments to this thesis. I am not convinced that the job is impossible in our system.

We are not without experience in managing huge systems which provoke intense political interest. We have, for example, managed Social Security and its growth despite the strains of divided responsibilities between Congress and the executive branch. Further, the work of the Commission appointed by President Reagan in 1981, a Commission dominated by Republican appointments, seemed to have produced a practical consensus for reform between the congressional leaders and the president.[12]

Universal health care contains many more complications than Social Security, including the presence of strong provider interests, but the politics

of Social Security provide reasons and experience to be hopeful about our prospects.

Finally, another strategic issue is where to locate the management of the system. England and Canada manage cost control by giving it strong executive branch leadership, and by making it an explicit electoral issue. Germany isolates the issue from the formal government, and from some of the vicissitudes of day-to-day electoral politics. Our temptation might be to emulate the German example.

The difficulty is that the Germans are working out of a tradition of corporatism that is almost completely unknown to the United States. Moreover, roughly half of all health care expenditure here comes from the government. In Germany, the entire system is funded off-budget. Thus, if we retain employment-based insurance in an overall scheme, we must somehow couple together tax and premium increases.

This may be the most complicated task facing Americans in implementing universal health care. At the national level I am convinced that our most feasible option is for a universal health care program built around Medicare. In such a scheme, Medicaid should be federalized and folded into the Medicare program. Medicare should be reformed in other ways, as Robert Ball has suggested.[13] I would go further and argue for a single Medicare card, with a national claims clearinghouse to be used by private insurers. Such a program would create a health care sector relatively isolated from the larger marketplace. It would also create a strong, universal entitlement for everyone, a strong element of taxpayer and premium-payer solidarity. Congress and the president would face strong pressures from the middle class to fund the entire system at adequate levels but not inflationary levels, and would be discouraged by the universal structure from isolating the poor from the rest of the system.

David Axelrod was absolutely convinced that universal health care was an unavoidable responsibility of every democratic society. Outside of Hawaii, Commissioner Axelrod stood almost alone among public health commissioners willing to take on the challenge. He also knew that ultimately this was a federal responsibility. He believed that, in one way or another, New York was destined to play a pivotal role in this national debate. He was determined that role should be conducted as constructively and as progressively as was possible. This is the standard by which Universal New York Health Care or UNY*Care should be judged.

## *REFERENCES*

1. Bowsher, C.A., Comptroller General of the United States: U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform. Statement before the Committee on Ways and Means, House of Representatives, April 17, 1991.

2. The Congress of the United States, Congressional Budget Office: *Rising Health Care Costs: Causes, Implications, and Strategies.* Washington, D.C., Govt. Print. Off., 1991.
3. Bodenheimer: The payment mechanism under a national health program. *Med. Care Rev.46:* 3–43, 1989.
4. Diamond, P.: A Proposal for Universal Coverage Through Compulsory Group Health Insurance. Unpublished manuscript, July 27, 1991.
5. The definitive statement for this view is Lowi, T.: American business, public policy, case studies and political theory. *World Pol. 16:*677–715, 1964.
6. See my Universal Health Care, American Style (forthcoming in *The Kennedy Institute on Ethics Journal*) for a review of these ideas about the impact of social insurance on politics. Thomas Edsall, in his *The New Politics of Inequality*, Norton, 1984, reviews the way in which "broadgauged" policies could remake American politics. This point also occurs in the literature of social welfare and social administration, and with the distinction between universal and selective benefits. See Richard, in his *The Philosophy of Welfare: Selected Writings of Richard M. Titmuss.* Brian Abel-Smith and Kay Titmuss, editors, he reviews many of these issues. See especially Chapter 7, Universal and Selective Social Service. See also Marshall, T.H.: *Citizenship and Social Class and Other Essays.* Cambridge: Cambridge University Press, 1950.
7. Beauchamp, D.E. and Rouse, R.: Universal New York health care: A single payer strategy linking cost control and universal access. *N. Engl. J. Med. 323:*640–644, 1990.
8. Reinhardt, U.: West German's Health-Care and Health-Insurance System. Unpublished manuscript, August 30, 1989; revised June 25, 1990.
9. Bodenheimer, op. cit.
10. Evans, R.G., Lomas, J., Barer, M.L.: Controlling health expenditures—The Canadian reality. *N. Engl. J. of Med. 320:*571–577, 1989.
11. Holmes, S.: The liberal idea. *Am. Prospect*, No. 7, 81–96, 1991.
12. Bernstein, M.C. and Bernstein, J.B.: *Social Security—The System That Works.* New York, Basic Books, 1988.
13. Ball, R.: A Public/Private Partnership Providing Health Care for All: Building on What We Have. Unpublished manuscript, April 8, 1991.